Initial Approval: January 9, 2019

CRITERIA FOR PRIOR AUTHORIZATION

Arikayce® (amikacin oral inhalation)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: All dosage forms of the following medications will require prior authorization.
Amikacin oral inhalation (Arikayce®)

CRITERIA FOR INITIAL APPROVAL: (must meet all of the following)

- Patient must be ≥ 18 years of age
- Patient has a diagnosis of refractory Mycobacterium avium complex (MAC) lung disease
- Arikayce must be used as a part of a combination antibacterial drug regimen
- Patient must have experienced an inadequate response to a combination antibacterial drug therapy regimen which includes either azithromycin or clarithromycin
    - Trial duration must be greater than or equal to 6 months
- Prescriber must provide documentation of all previous medication trials. Documentation must include the medication name(s), trial date(s) and outcome(s) of the trial (i.e. inadequate response, intolerance or contraindication, sputum culture results)
- Dose must not exceed 590 mg (one vial) daily

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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DATE

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PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE